



Adult Patient Information

Date: _____

Your Name: _____ I like to be called: _____

How did you hear about us? _____

Reason for the visit today? _____

Birthdate: ____/____/____ Age: ____ Sex: ____ Male ____ Female

Address: _____

Street

City

Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ City: _____ Occupation: _____

Email address: _____

Marital Status: Single ____ Married ____ Widowed ____ Seperated ____ Divorced ____

Spouse's Name: _____

Employer: _____ City: _____ Occupation: _____

Work Phone: _____

Dental Insurance Information

Insured's Name: _____ Insured's Social Security #: _____

Insurance Company: _____ Group No. _____ Local No. _____

Insurance Co. Address: _____ Phone No. _____

Do you have orthodontic coverage? Yes ____ No ____

Do you have dual coverage? Yes ____ No ____ If yes:

Insured's Name: _____ Insured's Social Security #: _____

Insurance Company: _____ Group No. _____ Local No. _____

Insurance Co. Address: _____ Phone No. _____

If you have any orthodontic insurance, we will assist you in receiving your maximum allowable benefits.

I understand that insurance claims will be submitted by Dr. Fodero's office. I understand that I am responsible for all charges not payed to Dr. Fodero by my insurance. I authorize release of any information relating to this claim to the insurance carrier.

Signature: _____ Date: _____

Dental History

Your General Dentist: _____ Date of last visit: _____

Address: _____

City

State

Zip

Yes No Have you had previous orthodontic treatment? Describe: _____
Yes No Any injuries to teeth, mouth, or jaws? Describe: _____
Yes No Do you require antibiotics before teeth cleaning or other dental appointments?
Yes No Does your lower jaw ever click or get sore? If yes, when? _____
Yes No Do you ever clench your teeth during the day? _____
Yes No Have you ever been told you grind your teeth? _____
Yes No Do you ever have trouble opening as far as you would like? _____
Yes No Have you ever been informed of having any missing or extra permanent teeth? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Have you ever seen a periodontist for periodontal treatment? _____

Any other dental problems that we should know about? _____

What specific concerns do you have regarding your teeth and how they look and function? _____

Medical History

Your Physician: _____ Date of last visit: _____

Address: _____

City

State

Zip

Circle any of the medical conditions below for which you have been treated:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Tuberculosis
Bone Disorders	Heart Problems	Kidney Problems	Tumor or Cancer
Congenital Heart Defect	Heart Murmur	Nervous Disorders	

Please Circle Yes or No (If Yes, please fill in details)

Yes No Are you allergic to any medication? _____
Yes No Are you allergic to latex? _____
Yes No Are you taking any medication: _____
Yes No Do you smoke or chew tobacco? _____
Female patients only:
Yes No Are you pregnant? _____
Yes No Any other special problems not listed above? _____

What days and times work best for you scheduling appointments: _____